Law Office
W. HOLT SMITH
209 Tellico Street North
Madisonville, Tennessee 37354
Phone: (423) 442-4012 (865) 522-4770
Fax: (423) 442-1038
whs4849@bellsouth.net

March 18, 2016

CERTIFIED—RETURN RECEIPT and REGULAR MAIL

Parkridge Medical Center, Inc.
d/b/a Parkridge Medical Center
% C T Corporation System
Suite 2021
800 S. Gay Street
Knoxville, Tennessee 37929-9710

RE: Notice of Potential Claim

Dear Sir:

Please be advised that I represent Barry Lynn Mealer. By this letter, which you are receiving by both Certified Return Receipt and regular mail, we are asserting a potential claim for medical malpractice.

The full name and date of birth for the patient is:
Barry Lynn Mealer DOB: 6/10/56

A HIPAA compliant medical authorization permitting you to obtain complete medical records from each of the other providers receiving notice is enclosed. Healthcare providers to whom a notice is being sent include Parkridge Medical Center, Inc.

Best personal regards.

Very truly yours,

W. HOLT SMITH
WHS:rb
Enclosure

NOTICE OF POTENTIAL CLAIM
FOR MEDICAL MALPRACTICE

Pursuant to **Tennessee Code Annotated** § 29-26-121, this Notice of Potential Claim for Medical Malpractice is being provided at least sixty (60) days before the filing of a complaint.

PATIENT NAME: **Barry Lynn Mealer**
ADDRESS: **Life Care Center of Copper Basin**
166 Industrial Drive
Copper Basin, Tennessee 37317
DATE OF BIRTH: **6/10/56**
SPOUSE: **n/a**

NAME, ADDRESS, AND RELATIONSHIP TO PATIENT OF CLAIMANT AUTHORIZING THIS NOTICE IF NOTICE NOT SENT BY PATIENT:

NAME AND ADDRESS OF ATTORNEY SENDING NOTICE:
W. Holt Smith
209 Tellico Street North
Madisonville, Tennessee 37354

NAME AND ADDRESS OF ALL PROVIDERS BEING SENT NOTICE:

Parkridge Medical Center, Inc.
d/b/a Parkridge Medical Center
% C T Corporation System
Suite 2021
800 S. Gay Street
Knoxville, Tennessee 37929-9710

Parkridge Medical Center, Inc.
d/b/a Parkridge Medical Center
1 Park Plaza
Nashville, Tennessee 37203-6527

Attached to this Notice of Potential Claim is a HIPAA compliant medical authorization permitting you to obtain complete medical records from each other provider receiving a Notice of Potential Claim.

W. HOLT SMITH
Attorney at Law
209 Tellico Street North Madisonville, Tennessee 37354
Phone: (423) 442-4012 or (865) 522-4770 Fax: (423) 442-1038

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

This authorization form is compliant with Tennessee and Federal privacy laws, including the Health Insurance Portability and Accountability Act.

Patient Name: Barry Lynn Mealer
Date of Birth: 6/10/56

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

   Parkridge Medical Center, Inc.
   d/b/a Parkridge Medical Center
   1 Park Plaza
   Nashville, Tennessee 37203-6527

3. The above firm's agents and employees are also authorized to inspect the originals of all such records. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

   A complete copy of the medical record for treatment to the present day.

4. This request is: _____ **a workers' compensation injury**
   _X_ **not a workers' compensation injury.**

5. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
6. This information may be disclosed to and used by the following individual or organization for the purpose of obtaining medical and/or financial information for the purpose of litigation involving the individual:

   Parkridge Medical Center, Inc.
   d/b/a Parkridge Medical Center
   % C T Corporation System
   Suite 2021
   800 S. Gay Street
   Knoxville, Tennessee 37929-9710

7. I understand I have a right to revoke this authorization at any time by notifying the providing organization in writing, but such revocation will only be effective from the date it is received and will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: **Two (2) years from date of receipt.**
8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Law Office of W. Holt Smith.
9. A photocopy of this authorization has the same force and effect as the original executed authorization.

X Barry Mealer 3/21/16

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, description of such representative's authority to act for the patient.

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1 Park Plaza
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Very truly yours,

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WHS:rb
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SPOUSE: **n/a**

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209 Tellico Street North
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1 Park Plaza
Nashville, Tennessee 37203-6527

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Attorney at Law
209 Tellico Street North Madisonville, Tennessee 37354
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Date of Birth:	6/10/56

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> Parkridge Medical Center, Inc.
> d/b/a Parkridge Medical Center
> 1 Park Plaza
> Nashville, Tennessee 37203-6527

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9. A photocopy of this authorization has the same force and effect as the original executed authorization.

[signature]
Signature of Patient or Legal Representative

3/21/16
Date

____
If Signed by Legal Representative, description of such representative's authority to act for the patient.